Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
7410 1 2741	or contraction	BENTH TO THE TOTAL BENT	A. BUILDING: 01		00 22.12	
		HAL025026	B. WING		07/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVERST	ONE) BOULEVAI N, NC 2856			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	This is a Report of a Biennial Construction Survey conducted by Greg Cates and Billy Bryant on July 21, 2015.					
	Facility was first lice licensure on or abo Sixty-Four (64) resi information, we are the 1984 Minimum Homes for the Age portions of the 2009 Seven or More Bed	on gathered from our files, the ensed or submitted for ut October 1, 1985 for dents. Based on this requiring the facility to meet Standards and Regulations for d and Disabled; the applicable Rules for Adult care Home of s; and the 1978 Edition of the e Building Code, Revision 5 tional Occupancy.				
C 164	Housekeeping and	Furnishings-Clean, Repaired	C 164			
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	06 HOUSEKEEPING AND es shall: ings, and floors or floor n and in good repair;				
		et as evidenced by: rations, the facility has failed to clean and in good repair.				
	build-up around the meet the walls at th doorways.	acility, there is wax/ dirt door frames, where the floors e vinyl base, and in the area of stained floor tiles in the				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		HAL025026	B. WING		07/21/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVERS	TONE	104 EFIRE	BOULEVA	RD		
MIVERO	ONE	NEW BER	N, NC 2856	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C 164	Continued From pa	ge 1	C 164			
	cracked, and discol d- The floor tiles at cracked. 2- Based on observ	the Beauty Shop are broken, ored. the fire doors (both halls) are rations, the facility has failed to blean and in good repair.				
	Findings include:					
	stained. b- There is a patter wallcovering throug examples include b 1- Shower Roo 2- Resident Ro 3- Resident Ro c- The walls in the b 110 are damaged a d- One of the walls Room 103 has a ho e- The wall located 127 is spattered an f- The grout in the t and appears to be g g- The grout is miss Room 1. 3- Based on observ	hout the facility. Specific ut are not limited to: m 6. om 129 om 126 pathroom of Resident Room and in need of repair. in the bathroom of Resident Room de in it. at the bed in Resident Room de badly stained. It is of Shower Room 2 is dirty growing mildew. It is sing in the shower of Bathing rations, the facility has failed to 's furniture in a clean and				
	Findings include:					
	and in bad repair.	Resident Room 115 is torn and bed in Resident Room				

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129 are broken and the mattress is in bad repair.

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		HAL025026	B. WING		07/2	1/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0172	172010	
RIVERSTONE 104 EFIRD			D BOULEVAI	RD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 166	SECTION .0300 - F 10A NCAC 13F .03 FURNISHINGS (a) Adult care home (5) be maintained i orderly manner, fre hazards; (e) This Rule shall facilities. This Rule is not me 1- Based on observate he building at maintained. Findings include: a- In the kitchen, the that is severely rust b- The handrails the corridors have a rest to the touch. c- In the Staff Breal moulding has splint exposed. d- The corridor dood delaminating. 2- Based on observation maintain the building findings include: a- In Room 127, the is falling off the hing b- In Shower Room commode is loose in the staff shower room commode in the staff shower room commode is loose in the staff shower room commode in the staff shower room commode is loose in the staff shower room commode in the staff shower room commode is loose in the staff shower room commode in the staff shower room commode is loose in the staff shower room commode in the staff shower room commode is loose the staff shower room commode in the staff shower room commode is loose the staff shower room commode in the staff shower room commode is loose the staff shower room commode in the staff shower room commode is loose the staff shower room commode in the staff shower room commode is loose the staff show	es shall: in an uncluttered, clean and e of all obstructions and apply to new and existing et as evidenced by: vation, the facility has failed to end its environment clean and ere is a metal shelving unit ed. roughout the facility 's sidue on them and are sticky kroom, the wood base ered and has rough edges er to the Staff Breakroom is vations, the facility has failed to eg free of hazards.	C 166				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		HAL025026	B. WING		07/2	1/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0.72		
RIVERS	ΓONE		D BOULEVAI N, NC 2856				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 166	there is an electrical equipped with overle- e- There are items electrical panel in the function of the corridor, the approximately ½-3/ providing a trip haz g- There are oxyge following areas that containers or in corproper support to publications to include 1-100 Hall Med 2-100 Hall Utili 3- Oxygen Stor	Care Coordinator 's office, al extension device that is not load protection. being stored in front of the ne Old Med Room. ne plumbing clean-outs are 4 inches below the floor level, ard. n bottles located in the tare either not stored in nationers that do not provide revent them from falling over. the but not limited to: d Room ity Room	C 166				
C 189	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plicare home shall be operating condition (k) This Rule shall facilities with the exwhich shall not app This Rule is not median to the shall of the shall not app	and all fire safety, electrical, sumbing equipment in an adult maintained in a safe and apply to new and existing acception of Paragraph (e) ly to existing facilities. Let as evidenced by: vations, plumbing systems are and operating. These fect residents, staff, or visitors	C 189				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
		HAL025026	B. WING		07/21/2015	
		TIALUZUZU			0112	1/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIVEDO	ONE	104 EFIRI	BOULEVA	RD		
RIVERST	ONE	NEW BER	N, NC 2856	2		
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	PRIATE	DATE
				DEFICIENCY)		
C 189	Continued From pa	ne 4	C 189			
0 100	Continued i form pu	90 4	0 .00			
	Findings on include	:				
		I in the Sanitation Room is not				
		water, is severely stained, and				
	is not equipped with					
		the Toilet Room beside the				
	Sanitation is soiled					
		n the following rooms are				
		tion to the floor and water is				
		base. Locations include but				
	are not limited to:					
	1- Resident Ro					
	2- Shower Room 3 d- The water cooler located beside the drink					
	machines does not work					
	0.5					
		rations, electrical systems are				
		e and operating. These				
	_	fect residents, staff, or visitors				
	wno may work, occ	upy, or visit the facility.				
	Finalinan in alcela.					
	Findings include:					
	a. The coiling maur	ated fluorescent light fixture in				
		nted fluorescent light fixture in				
	the Laundry has no					
		led Room, the following items				
		ude, but not limited to:				
		uplex receptacle that has no				
	cover	noo light has no globa				
		nce light has no globe.				
	c- The 100 Hall Utility Room light does not work. d- In the Living Room, there is a duplex					
	in the wall.	ft of the fireplace that is loose				
		coiling mounted light fixture				
		e ceiling mounted light fixture				
	has no cover.					
	3_ Rased on observ	rations, fire safety systems are				
		e and operating. These				
	not maintained Sale	and operating. These	[

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				K3) DATE SURVEY COMPLETED	
		HAL025026	B. WING		07/21/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
RIVERS1	ONE		D BOULEVAI N, NC 2856				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE		
C 189	Continued From pa	ge 5	C 189				
	deficiencies may af who live, work, or v	fect residents, staff, or visitors isit the facility.					
	Findings include:						
	areas do not work of include but are not 1- Activity Room 2- Living Room b- The screws are pon the Central Hall difficult to open in the 4- Based on observensure that the built the fire resistance of deficiency directly a and visitors by allow	oulling out of the door/closer EXIT door, making the door he event of an emergency. vations, the facility failed to ding is safe by not maintaining of building components. This affect all residents, personnel, wing the possible spread of compartment of origin.					
	following locations of the insulated pitch 2- There is a laceiling of the kitch 3- There is a laceiling of Room both the corridor doo beside the Med Room to the corridor doo beside the Med Room to the corridor doo the solution to the corridor doo beside the Med Room to the corridor doo the solution to the corridor doo	rge, open crack in the tchen. rge, open crack in the					
C 199	Exhaust Ventilation		C 199				
	SECTION .0300 - F	PHYSICAL PLANT					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL025026	B. WING		07/2	1/2015
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
RIVERS	TONE		D BOULEVAI NN, NC 2856			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 199	10A NCAC 13F .03 REQUIREMENTS (g) The spaces list provided with exhaut two cubic feet per requirement does no before April 1, 1984 these specified space (1) soiled linen store (2) soil utility rooms (3) bathrooms and (4) housekeeping (5) laundry area. (k) This Rule shall facilities with the exwhich shall not app This Rule is not mean 1- Based on observation has failed to maintain systems in working. Findings include: a- The exhaust fan completely clogged b- There are cleaning two cubic provides and completely clogged b- There are cleaning the control of the completely clogged b- There are cleaning the complete clogged clogged b- There are cleaning the complete clogged c	ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This iot apply to facilities licensed with natural ventilation in ces: rage; toilet rooms; closets; and apply to new and existing ception of Paragraph (e) ly to existing facilities. Let as evidenced by: rations and testing, the facility in the mechanical exhaust condition. grille in the Laundry Room is with lint. ng chemicals being stored in however there is no	C 199			

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